The Hilltop Institute

analysis to advance the health of vulnerable populations

Network Adequacy and Essential Community Providers Workgroup: A Report to the Maryland Health Benefit Exchange Board of Trustees

September 11, 2015

UMBC

AN HONORS UNIVERSITY IN MARYLAND

Network Adequacy and Essential Community Providers

Table of Contents

Executive Summary i
Introduction 1
Background 2
Federal Requirements 2
Affordable Care Act (ACA) Statute and Regulations 2
Federally Facilitated Marketplace (FFM) Requirements 3
Other States 4
Network Adequacy 4
ECPs 8
Maryland Landscape 9
MHBE Policy 9
ECPs in Maryland 10
Maryland Insurance Code 10
Health Plan Accreditation Requirements 13
Maryland Medicaid Requirements 14
Medicare Requirements 15
Continuity of Care Requirements 16
Other Considerations 16
National Association of Insurance Commissioners 16
Balancing Access and Costs 17
Network Adequacy Data Sources in Maryland 21
MHBE Data 21
Maryland Health Care Commission (MHCC) Data 21
MIA Data 22
Maryland Medicaid Data 22
Policy Options 23
Areas of Consensus 25

1. Data Collection and Reporting Policy Options..25
2. Provider Directory Policy Options..29
3. ECP Policy Options..31
4. Quantitative Standards Policy Options..33
5. Informing Consumers Policy Options..37
Next Steps..39
References..40
Appendix A. Network Adequacy and ECP Workgroup Membership..43
Appendix B. Written Public Comments and Additional Workgroup Member Comments..........44

Executive Summary

Introduction

Network adequacy refers to a health plan's ability to provide reasonable access to sufficient in-network providers, and essential community providers (ECPs) serve low-income and medically underserved populations (McCarty & Farris, 2013). Pursuant to federal regulations, the Maryland Health Benefit Exchange (MHBE) is interested in further developing policies for ECPs and provider network adequacy. To achieve this goal, the MHBE tasked its Standing Advisory Committee (SAC) to create a Network Adequacy and ECP Workgroup (Workgroup), charged with reviewing background materials and developing and assessing various policy options for provider network standards.

Workgroup Process

The Workgroup included 16 members, representing carriers, providers, and consumer advocacy organizations. The Workgroup met seven times between May and August 2015, and the SAC met on September 10, 2015, to review this report. The Workgroup reviewed federal and state law related to network adequacy and ECPs, network adequacy data sources, and network adequacy and ECP standards in other states. Reflecting on the discussions at these meetings, the Workgroup then developed policy options for the MHBE's consideration, providing advantages, disadvantages, and other considerations for each. The options are intended to provide a range for consideration and could be implemented in isolation or in combination with other options. Workgroup members and the public were given the opportunity to comment on these options. Public comments are included in Appendix B and Attachment 1. The purpose of this report is to provide input to the MHBE Board of Trustees for the 2017 benefit year.

Policy Options

The Workgroup developed a total of 16 policy options in the following topic areas: data collection and reporting, provider directories, ECPs, quantitative standards, and informing consumers. The Workgroup reached consensus on seven policy options. In its September 10 meeting, the SAC also reached consensus on these seven options:

Policy Options with Consensus

Data Collection and Reporting Options:

- The MHBE should work with the Maryland Health Care Commission (MHCC) to analyze network adequacy using claims and encounter data.

- The MHBE should work with Medicaid and other divisions of the Maryland Department of Health and Mental Hygiene (DHMH) to assess the number, capacity, and types of providers in the state, especially mental health and substance use disorder providers, provider organizations, and programs, in order to identify willing providers.
- The MHBE should work with the licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers in the state and other data, such as provider specialty.

Provider Directory Options:

- The MHBE should work with the Maryland Insurance Administration (MIA), carriers, providers, and consumer groups to improve the accuracy of provider directories.
- The MHBE should consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories.

ECP Options:

- The MHBE should work with state partners to create an ongoing process, using Maryland data sources, to ensure that the Centers for Medicare & Medicaid Services' list of Maryland ECPs is accurate and complete.

Informing Consumers Options:

- The MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the Office of the Attorney General's Health Education and Advocacy Unit (HEAU) to develop messaging and a reasonable process to inform consumers on how to find a provider and how to obtain relief when they cannot find a provider, pursuant to Ins. Art. §15-830(d).

Policy Options without Consensus

The Workgroup developed and discussed nine other policy options, but was unable to reach consensus on these options.

Data Collection and Reporting Options:

- The MHBE should work with the MHCC, providers, payers, carriers, and consumer groups to expand the consumer satisfaction data collected and made accessible, and determine specific ways to make the data more transparent to the public (e.g., consumer report cards).

Provider Directory Options:

- The MHBE should expand on the types of providers that are included in provider directories, such as including mental health and substance use disorder programs, in addition to individual practitioners.
- The MHBE should assess the feasibility of developing a standard taxonomy for provider types.

ECP Options:

- The MHBE should expand the definition of ECPs beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers.
- The MHBE should use the federally facilitated marketplace (FFM) threshold for ECP participation and the FFM alternate standard for qualifying carriers.

Quantitative Standards Options:

- The MHBE should collect data regarding network adequacy and consider developing quantitative standards in the future.
- The MHBE should work with the MIA, consumer groups, and carriers to define the current unreasonable delay standard so that consumers will better understand when they can see an out-of-network provider with in-network cost-sharing.
- The MHBE should work with the MIA to make the quantitative standards used and reported by carriers in their availability plans submitted to the MIA and access plans submitted to the MHBE publicly accessible.
- The MHBE should work with the MIA to standardize the format for reporting quantitative standards in availability plans the MIA requires, and with DHMH to standardize the format for reporting quantitative standards in availability plans DHMH requires.

Next Steps

This report will be presented to the MHBE Board on September 15, 2015. In October, the Board will begin discussing policy recommendations for the 2017 plan year, as it starts to set the qualified health plan certification standards. The MHBE may convene the Workgroup again in the future to continually monitor these issues.

Introduction

Network adequacy refers to a health plan's ability to provide reasonable access to sufficient in-network providers (McCarty & Farris, 2013). Essential community providers (ECPs) serve low-income and medically underserved populations and include such providers as federally qualified health centers (FQHCs), Ryan White designated providers, family planning clinics, Indian health providers, and specified hospitals. Pursuant to federal regulations, the Maryland Health Benefit Exchange (MHBE) is interested in further developing policies for ECPs and provider network adequacy. To achieve this goal, the MHBE tasked its Standing Advisory Committee (SAC) to create a Network Adequacy and ECP Workgroup (Workgroup), charged with reviewing background materials and developing and assessing various policy options for provider network standards. The Workgroup included 16 members, representing carriers, providers, and consumer advocacy organizations. See Appendix A for a list of members and their affiliations. The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) developed background materials for the Workgroup's review. The Workgroup met seven times between May and August 2015. This report summarizes the background materials and the Workgroup's discussions. The purpose of this report is to provide input to the MHBE Board of Trustees for the 2017 benefit year.

This report first provides background information on federal requirements for network adequacy and ECPs, standards in other states, current policies in Maryland, and other considerations. Next is an overview of network adequacy data sources in Maryland. Finally, this report summarizes the policy options reviewed by the Workgroup, describing potential advantages, disadvantages, and other considerations related to each option.

Background

Federal Requirements

Affordable Care Act (ACA) Statute and Regulations

Section 1311 of the ACA[1] requires the Secretary of the U.S. Department of Health and Human Services (HHS) to establish criteria for the certification of qualified health plans (QHPs). The certification criteria must contain requirements to:

- Ensure a sufficient choice of providers
- Provide information to enrollees and prospective enrollees about the availability of both in-network and out-of-network providers
- Include ECPs that serve the low income and medically underserved populations within the provider networks[2]

Federal regulations lay out the criteria for QHP certification,[3] including requirements related to network adequacy and ECPs. Specifically, regulations require that issuers:

- Maintain networks that are "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services to assure that all services are accessible without unreasonable delay."[4]
- Include ECPs in their provider networks. These ECPs must be "sufficient in number and geographic distribution" to ensure that reasonable and timely access is provided to the medically underserved individuals within the QHP's service area, and in accordance with the applicable exchange's network adequacy standards.[5]

Federal regulations have an alternate standard for QHP issuers that provide a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group. These issuers must have a "sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities," to ensure that reasonable and timely access is provided to the medically underserved individuals within the QHP's service area and in accordance with the applicable exchange's network adequacy standards.[6]

---

[1] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18001 (Supp. 2010)).
[2] 42 U.S.C. §18031
[3] 45 CFR Part 156, Subpart C.
[4] 45 CFR §156.230(a)(2).
[5] 45 CFR §156.235(a)(1).
[6] 45 CFR §156.235(b).

In February 2015, HHS published a *Final Notice of Benefit and Payment Parameters for 2016*, which included modifications to the network adequacy and ECP standards.[7] The notice contained a new provision requiring issuers to publish an up-to-date, accurate, and complete provider directory that includes information specifying: the providers who are accepting new patients, location, contact information, specialty, medical group, and any institutional affiliations. Further, the ECP definition was expanded to include state-owned, governmental, or nonprofit family planning service sites and Indian health care providers. The ECP standard was modified to require QHP issuers to ensure reasonable and timely access to a broad range of ECPs for low-income, medically underserved individuals in *health professional shortage areas* (HPSAs) within the QHP's service area.

Federally Facilitated Marketplace (FFM) Requirements

For the 2015 and 2016 benefit years, HHS set a more specific standard for issuers that offer plans through the FFM. As a state-based marketplace, Maryland does not have to meet these requirements. For the 2015 benefit year, issuers offering plans through the FFM must demonstrate in their applications for QHP certification that at least 30 percent of available ECPs in the plan's service area will participate in the provider network. If an issuer's application does not satisfy this requirement, then the issuer must provide a satisfactory narrative justification of this failure.[8]

For the 2016 benefit year, issuers must offer contracts to all available Indian health providers in the service area, and at least one ECP in each ECP category (FQHCs, Ryan White providers, family planning providers, Indian Health providers, hospitals, and other ECP providers) in each county within the service area where an ECP in that category is available.[9] The contract must be offered in good faith and should offer the same rates and contract provisions as other contracts accepted by, or offered to, similar non-ECP providers. In addition, issuers will continue to be required to demonstrate that at least 30 percent of available ECPs in the plan's service area will participate in the provider network or, in the alternative, provide a satisfactory narrative justifying the failure to meet it.[10]

[7] See 80 Fed. Reg. 10,830 (finalized February 27, 2015).
[8] 2015 Letter to Issuers in the Federally-facilitated Marketplaces (March 14, 2014). Retrieved from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf
[9] See 80 Fed. Reg. 10,830 (finalized February 27, 2015).
[10] 2016 Letter to Issuers in the Federally-facilitated Marketplaces (February 20, 2015). Retrieved from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf

Other States

Network Adequacy

The ACA provides state-based marketplaces with considerable flexibility in interpreting the federal standards for network adequacy and in enacting additional requirements. States are currently using two overarching approaches for establishing network adequacy standards: quantitative and subjective standards (Corlette, Volk, Berenson, & Feder, 2014). Examples of quantitative standards include: provider-to-enrollee ratios, maximum travel time and distance, maximum appointment wait times, minimum number of providers accepting new patients, and minimum percentage of available providers within a service area (Corlette, Volk, et al., 2014). Subjective standards are more flexible and are similar to the reasonable access standard used in the federal regulations. Quantitative standards have the advantage of clarity and equity among insurers (Corlette, Volk, et al., 2014). However, geographic and market differences across a state may make it difficult to set a standard that accounts for these differences, and many state insurance regulators may not have the ability to conduct comprehensive, pre-market review of an insurer's provider networks (Corlette, Volk, et al., 2014). A subjective approach gives insurers more flexibility, but, without a clear standard, it is difficult to determine when a plan's network is too narrow to make health care services available without undue delay (Corlette, Volk, et al., 2014).

The Commonwealth Fund published a study in May 2015 examining the network adequacy standards applicable to exchange plans across the county at the beginning of exchange coverage in 2014 (Giovannelli, Lucia, & Corlette, 2015). The study found that by January 2014, nearly all states had network adequacy rules, though there was great variation in the standards used (Giovannelli et al., 2015). In many states, the rules only applied to specific plan types, such as health maintenance organizations (HMOs) (Giovannelli et al., 2015). Twenty-one states had qualitative standards, similar to the federal requirement to maintain sufficient networks to ensure enrollees can receive services without undue delay (Giovannelli et al., 2015). In contrast, 27 states had quantitative standards, which took different forms (Giovannelli et al., 2015).

- Twenty-three states specified the maximum amount of time and/or distance an enrollee must travel to see a provider. For example, New Jersey requires managed care plans to make at least two primary care physicians available within 10 miles or 30 minutes driving or public transit time for 90 percent of its enrollees.
- Eleven states imposed maximum wait times for an appointment, and ten states prescribed minimum provider to enrollee ratios. For example, Montana required plans to ensure access to urgent care with 24 hours, non-urgent care with symptoms within 10 days, immunizations within 21 days, and routine services within 45 days.
- Ten states had minimum provider-to-enrollee ratios. For example, Nevada required exchange plans to provide at least one internal medicine provider for every 2,500

enrollees and for certain specialized services, such as one cardiologist for every 7,500 enrollees.

- Seven states required plans to ensure access to providers at flexible times or outside business hours. For example, California required certain network plans to include providers that offer nonemergency services until 10 p.m., or for at least four hours each Saturday.

Most states did not adopt additional requirements for provider directories beyond the federal standard to make provider directories available online and in hardcopy upon request (Giovannelli et al., 2015). Nine states required plans to update their directories at fixed intervals during the year, and Arkansas required insurers to update a directory within 14 days of any changes (Giovannelli et al., 2015). Table 1 provides a comparison of exchange plan network adequacy standards as of January 2014.

Table 1. Comparison of QHP State Provider Network Adequacy Standards as of January 2014

State	Qualitative Standard Only	Maximum Travel Time	Provider: Enrollee Ratio	Maximum Appointment Wait Time	Hours of Operation	Provider Directory
AL		X*				
AK	X					
AZ		X*		X*		X*
AR	X					X
CA		X	X	X*	X	X
CO	X					X
CT	X					
DE		X	X	X		
DC	X					
FL		X*		X*		
GA	X					X
HI	X					
ID	X					
IL		X	X		X	
IN	X					
IA	X					
KS	X					
KY		X				
LA	X					
ME			X			

State	Qualitative Standard Only	Maximum Travel Time	Provider: Enrollee Ratio	Maximum Appointment Wait Time	Hours of Operation	Provider Directory
MD	X					X
MA	X					
MI		X				
MN		X*			X*	X
MS	X					
MO		X*		X*	X*	
MT		X*	X*	X*		
NE	X					
NV		X	X			X
NH		X		X		
NJ		X		X		
NM		X	X	X		
NY		X	X			
NC	X					
ND	X					
OH	X					
OK		X*				
OR	X					
PA		X*				
RI					X	
SC		X	X			
SD	X					
TN		X*				
TX		X*		X		X
UT	X					
VT		X		X		X
VA					X	
WA	X					
WV		X*	X*			
WI					X*	
WY	X					

*Standards apply only to specific types of plans

Source: Giovannelli, J, Lucia, K, & Corlette, S. (2015, May). *Implementing the Affordable Care Act state regulation of marketplace plan provider networks.*

By January 2015, few states adopted a new regulatory approach to network adequacy despite discussions by policymakers in most states (Giovannelli et al., 2015). Three states created new quantitative requirements. Arkansas set time and distance standards for plans; California adopted maximum appointment wait times; and Washington adopted more detailed network standards (Giovannelli et al., 2015). The changes in California and Washington are in part a response to litigation challenging network adequacy in QHPs. In Washington, Seattle Children's Hospital sued the insurance commissioner for certifying two health plans that excluded the hospital from their networks (Carlson, 2013). Several consumers in California have filed lawsuits against carriers offering QHPs, claiming that the insurers offered inadequate provider networks, and their provider directories were inaccurate (Appleby, 2014). Six states adopted stricter requirements regarding provider directories. For example, Washington included a requirement that plans update their directories on a monthly basis, and New York required online directories to be updated within 15 days of a network change (Giovannelli et al., 2015). At least six states (Arkansas, California, Mississippi, New Hampshire, New York, and Washington) increased the ability of regulators to oversee and enforce exchange plan requirements (Giovannelli et al., 2015). For example, Mississippi required each managed care plan to file a detailed report describing the plan's network and the insurer's procedures for complying with network adequacy standards (Giovannelli et al., 2015).

Table 2. States Adding QHP Quantitative Standards or Increasing Requirements to Update Provider Directories for 2015 Coverage, January 2015

State	Standard	Summary of New Requirements
Arkansas	Quantitative	Maximum travel time or distance
California	Quantitative; Provider directory	Maximum appointment wait times; directories must be updated weekly
Connecticut	Provider directory	Directories must be updated no less than quarterly
Nevada	Provider directory	Directories must be updated no less than every 60 days
New York	Provider directory	Directories must be updated within 15 days of a change
Rhode Island	Provider directory	Directories must be updated no less than monthly
Washington	Quantitative; Provider directory	Maximum travel time or distance; provider-to-enrollee ratios; maximum appointment wait times; directories must be updated no less than monthly

Source: Giovannelli, J, Lucia, K, & Corlette, S. (2015, May). *Implementing the Affordable Care Act state regulation of marketplace plan provider networks.*

In January 2015, California adopted emergency regulations related to provider network adequacy, which included maximum wait times for appointments that vary based on the type of provider and whether the care furnished is urgent or non-urgent (California Department of Insurance, 2015). For example, the maximum wait time for an urgent care appointment is 48 hours; for non-urgent primary care appointments, the maximum wait time is 10 business days (California Department of Insurance, 2015). Insurers are also required to make their provider directories available online, with weekly updates, and the directories must be accurate and conform to specific listing standards (California Department of Insurance, 2015).

ECPs

The Kaiser Family Foundation examined the ECP standards used by exchanges across the country in 2015. Fourteen states expanded the definition of ECP to include additional provider categories beyond the six CMS categories (Kaiser Family Foundation, 2015).

- Six states added rural health clinics.
- Four states added school-based health centers.
- Three states added providers who historically served or were committed to serving low-income and medically indigent patients.
- Three states added providers serving a certain percentage of Medicaid or low-income patients.

Table 3 summarizes these expanded ECP definitions by state.

Table 3. States with Expanded ECP Definitions

State	ECPs Included in Addition to CMS Categories (14 states)
Arkansas	School-based health clinics; Rural health centers
California	HI-TECH Medi-Cal Electronic Health Record Incentive Program providers
Colorado	Providers historically serving indigent patients, and low-income/medically indigent patients a significant portion of patients; Providers who waive charges/sliding scale based
Connecticut	School-based health clinics
Kentucky	Regional community services programs for mental health or individuals with an intellectual disability
Louisiana	Physicians historically serving Medicaid and indigent patients; Rural health clinics and rural small hospitals; Home health agencies; State-owned or operated hospitals
Minnesota	Providers with commitment to low-income/underserved; Former state hospitals that specialize in treating certain diseases; Birth centers; Hospitals and clinics that predominately serve patients under 21

State	ECPs Included in Addition to CMS Categories (14 states)
Missouri	Providers that have: 40% Medicaid, Medicare or uninsured patients; spend at 20+/week at a principal site; and evening/weekend hours
Montana	County health departments offering immunizations
Nebraska	Rural health clinics
New Mexico	School health programs linked to an eligible provider; Public health departments; Nonprofit primary care clinics; Home health agencies; Behavioral health agencies; Rural health clinics
South Carolina	Rural health clinics; Rural hospitals
Virginia	Providers with 20 percent or more Medicaid-eligible or other indigent patients
Washington	Providers with patient mix of 30 percent or more Medicaid patients approved for Electronic Medical Record Incentive Program; Long-term care facilities with average residency rate of 50+% Medicaid; School-based health centers; Rural health clinic or free clinic; Facilities/Providers waiving charges with sliding scale

Source: Kaiser Family Foundation. (2015). *Definition of essential community providers (ECPs) in marketplaces*.

Maryland Landscape

MHBE Policy

In 2012, the MHBE Board adopted interim procedures requiring QHP issuers in the state to follow the above-described federal regulations related to ECPs in state-based exchanges (but not those related to the FFM requirements).[11] These interim procedures covered year one of MHBE operations, including the first open enrollment. These policies are still in place today.

On April 15, 2014, the MHBE Board approved 2015 plan certification standards, including that, in addition to issuers following federal standards, the MHBE should conduct necessary analyses of the 2014 experience, seek input from the SAC, and develop recommended metrics for network adequacy and ECP engagement adequacy standards for the 2016 benefit year.[12]

On March 17, 2015, the MHBE Board approved 2016 plan certification standards. The 2016 network adequacy standards include a requirement that the provider list should be current (updated at least twice a month), accurate, and complete. The MHBE should continue to conduct analyses of helpful data, seek input from the SAC, and develop recommended metrics for network adequacy and ECP engagement adequacy standards for the 2017 benefit year.

[11]Maryland Health Benefit Exchange Carrier and Qualified Plan Certification Interim Procedures (October 23, 2012). Retrieved from http://marylandhbe.com/wp-content/uploads/2013/05/MHBE-QHP-Interim-10-23-20121.pdf
[12] See 2015 Plan Certification Standards and Stand-Alone Dental Plans Proposal (April 15, 2014).Retrieved from http://marylandhbe.com/wp-content/uploads/2014/04/MHBE-2015-Plan-Certification-Standards-and-Dental-Plans-Proposal.final_.4.15.14-2.pdf

ECPs in Maryland

The Centers for Medicare & Medicaid Services (CMS) maintains a non-exhaustive database of ECPs by state (CMS Center for Consumer Information and Insurance Oversight, 2015). According to this database, there are 195 identified ECPs in the state of Maryland for the 2016 benefit year. Table 4 presents the number of ECPs by county, according to CMS's non-exhaustive list.

Table 4. ECPs in Maryland by County, 2015 Benefit Year

County	Number of ECPs
Allegany	4
Anne Arundel	6
Baltimore City	58
Baltimore	15
Calvert	1
Caroline	14
Carroll	1
Cecil	2
Charles	3
Dorchester	5
Frederick	3
Garrett	5
Harford	3
Howard	4
Kent	2
Montgomery	16
Prince George's	15
Queen Anne's	2
Somerset	5
St. Mary's	3
Talbot	10
Washington	5
Wicomico	9
Worcester	4
Total	**195**

Maryland Insurance Code

The Insurance Article provides several requirements that insurers, nonprofit health service plans, and dental plan organizations (hereinafter referred to as "carriers" for the purposes of this

section) must abide by when using a provider panel. As such, these requirements are applicable to all QHPs offered for sale through the Maryland Health Connection (MHC). At the outset, the Insurance Article explains that carriers must maintain standards in accordance with regulations related to the availability of providers. Under these regulations, adopted by the Insurance Commissioner,[13] carriers must develop standards related to network adequacy, referred to as "provider panel sufficiency." While the Maryland Insurance Administration (MIA) does not have prior approval authority for these standards, it does have the authority to review whether carriers are meeting their own standards and can find them in violation.

The regulations first explain that carriers must maintain provider panels that are "sufficient in numbers and types to meet the health care needs of enrollees."[14] Beyond this general requirement, the regulations also require that the standards to meet the "health care needs" of the enrollees must be determined in accordance with reference to a reasonable, established criteria set by the carrier, which should at least include:

- Provider-to-enrollee ratios by specialty
- Primary care provider-to-enrollee ratios
- Geographic accessibility
- Waiting times for appointments with providers
- Hours of operation
- The volume of technological and specialty services available to serve the needs of enrollees requiring technologically advanced or specialty care[15]

The regulations also require that carriers implement an availability plan, laying out the "quantifiable and measurable standards for the number and geographic distribution of" several types of providers, ranging from internal medicine providers to high volume specialty mental health and substance use disorder providers.[16] When a carrier is a dental plan organization or is an insurer or nonprofit health service plan only providing dental service coverage, the availability plan must include standards for the number and geographic distribution of dentists and other dental service providers.[17]

In addition to these standards, the availability plan must include the methods used to 1) assess compliance with the standards set in the plan, 2) ensure timely access to health care services, and 3) monitor and ensure the sufficiency of the provider panel.[18]

[13] See COMAR 31.10.34.
[14] COMAR 31.10.34.04(A).
[15] COMAR 31.10.34.04(B).
[16] COMAR 31.10.34.05(A)(1).
[17] COMAR 31.10.34.05(A)(2).
[18] COMAR 31.10.34.05(B).

A carrier must review and update the availability plan on an annual basis and submit the plan to the Insurance Commissioner upon request. The requirement to submit the plan becomes mandatory for “prominent carriers,” or those reporting at least $90,000,000 in written premium for medical benefits in the state in their most recent annual statement.[19] Further, a carrier must conduct a performance assessment to determine compliance with the availability plan, using the methods it specifies in the plan.[20]

Finally, the regulations explain that when a carrier violates the regulations, the Commissioner may order a carrier to take reasonable appropriate corrective action, in addition to any other enforcement powers available to the Commissioner. Such corrective action can include meeting the standards set in the availability plan or making restitution to an enrollee harmed by the carrier’s failure to meet the standards set in the availability plan.[21]

HMOs are regulated by both the MIA and the Maryland Department of Health and Mental Hygiene (DHMH). The HMO network adequacy requirements, however, are regulated exclusively by DHMH.[22]

Insurers and nonprofit health service plans that issue exclusive provider plans—i.e., plans that limit care to in-network providers only, except for emergency services—are required to have the exclusive provider networks approved by the DHMH.[23] The exclusive provider plans are subject to the same regulations regarding network adequacy that apply to HMOs.

Other network adequacy provisions in the Insurance Article that apply to insurers, nonprofit health service plans, HMOs, and dental plan organizations include continuity of care provisions related to the termination of primary care physicians from the provider panel, requirements related to notifying prospective enrollees of the carrier’s provider panel, and requirements related to the updating of provider information subsequent to receiving updated information from a participating provider.[24] Insurers, nonprofit health service plans, HMOs, and dental plan organizations must also establish procedures for review of provider applications, for notifying enrollees of the termination of a primary care provider (PCP), for notifying PCPs of the termination of a specialty provider, and for verifying on a periodic basis whether a provider is accepting new patients.[25]

[19] COMAR 31.10.34.05(C)(2).
[20] COMAR 31.10.34.05(C)(1)(b).
[21] COMAR 31.10.34.06.
[22] Health-General Article, § 19-705.1(b)(1), Annotated Code of Maryland.
[23] Insurance Article, § 14-205.1, Annotated Code of Maryland.
[24] Insurance Article §§15-112(i), (j), and (m), Annotated Code of Maryland.
[25] Insurance Article §15-112(b), Annotated Code of Maryland.

Health Plan Accreditation Requirements

The MHBE requires all health plans offered through the MHC to be accredited. The National Committee for Quality Assurance (NCQA) is an accrediting body for health insurance issuers offering QHPs in exchanges.[26] The NCQA's accreditation program requires:

> plans to develop reasonable standards for access and availability of services and measure themselves against those standards. More specifically, plans must develop standards for the number and geographic distribution of providers – including primary care, specialty care, and mental health and substance use disorder providers. Plans must also set standards on the ability of members to get care – including regular appointments, urgent care appointments, after hours care, and member services by phone. They must collect data and analyze their performance against these standards using a statically valid methodology at least annually (NCQA, n.d.a., p. 6).

In reviewing health plans for accreditation, the NCQA considers the following related to network adequacy (NCQA, n.d.b.):

- Including practitioner locations throughout the plan's service area
- Considering the cultural needs of members
- Ensuring sufficient numbers of primary care and specialty providers
- Measuring performance and making improvements as necessary
- Having standards to ensure access to care, including routine primary care, behavioral health, emergency, and after-hours care

The NCQA also requires health plans to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, which asks beneficiaries questions about access to care (NCQA, n.d.a.).

For 2015, the NCQA updated its accreditation standards to address the growing trend of narrow networks. The NCQA added a network transparency requirement that health plans must disclose their criteria for including providers in their networks online, in easy-to-understand language. Health plans must also monitor complaints, appeals, and requests for out-of-network services to assess whether network size may undermine quality. These new standards only apply to marketplace plans (NCQA, 2014).

---

[26] Health plans may also be accredited by URAC, though it is less widely used. As part of its accreditation process, URAC assesses the number of specialists and primary care providers in a plan's network accepting new patients. For more information, please see URAC's Health Plan Measure Specifications at https://www.urac.org/wp-content/uploads/URAC_HP_HIX_Measure_Specifications_20150305.pdf .

The NCQA recently released updated standards for 2016 health plan accreditation. The new standards establish additional requirements regarding provider directories. Health plans must conduct annual assessments of their provider directories to determine whether the directories have accurate provider contact information and hospital affiliations, as well as identify whether a provider is accepting new patients or has an active network contract. The NCQA is also requiring a more comprehensive assessment of plan networks and is requiring insurers to inform enrollees of certain coverage details (NCQA, 2015).

Maryland Medicaid Requirements

Distinct from private insurance and QHP coverage administered by commercial carriers, Maryland Medicaid covers individuals determined to be categorically eligible or medically needy, and plays a critical role in serving low-income, uninsured individuals. The HealthChoice Program provides health care to most Medicaid participants, who enroll in a managed care organization (MCO) of their choice and select a primary care provider (PCP) to oversee their medical care. Some services (e.g., pediatric dental) are carved out of the MCO benefit package and are offered through the Medicaid fee-for-service (FFS) system.

Maryland Medicaid has several network adequacy requirements for its MCOs.[27] First, Medicaid requires a ratio of 1 PCP to every 200 participants within each of the 40 local access areas in the state. Because some PCPs traditionally serve a large volume of Medicaid participants at some of their sites, such as FQHCs, Medicaid may approve a ratio of up to 2,000 adult participants and 1,500 children per high-volume provider.

In addition to ensuring PCP network adequacy, DHMH requires MCOs to provide all medically necessary specialty care. If an MCO does not have the appropriate in-network specialist needed to meet the participant's medical needs, then the MCO must arrange for care with an out-of-network specialist and compensate the provider. Regulations for specialty care access require each MCO to have an in-network contract with at least one provider statewide in the following medical specialties: allergy, dermatology, endocrinology, infectious disease, nephrology, and pulmonology. Additionally, each MCO must include at least one in-network specialist in each of the ten regions throughout the state for the following eight core specialties: cardiology, otolaryngology, gastroenterology, neurology, ophthalmology, orthopedics, surgery, and urology.

Medicaid also has geographical access standards for primary care, pharmacy, OB/GYN, and diagnostic laboratory and x-ray services. An MCO must provide these services in urban areas, within 10 miles of each enrollee's residence; in rural areas, within 30 miles of each enrollee's residence; and n suburban areas, within 20 miles of each enrollee's residence.

Medicaid has the discretion to approve a network that does not meet these geographic access standards. Geo-mapping is done at the MCO level and is provided to the state for assessing

[27] COMAR 10.09.66.05-.08.

compliance with distance standards. These distance standards are set to be the maximum mileage, not an average. Medicaid does not use travel time because of its variability due to traffic conditions, type of transportation, road conditions, and other changing circumstances.

Medicaid requires MCOs to provide participants with a listing of primary care service locations, hospital providers, pharmacy providers, as well as primary and specialty care providers. The provider directory must include the provider's name, address, practice location, whether the provider is accepting new patients, and whether access to the provider is limited. An MCO should make a good faith effort to keep DHMH's online directory accurate by submitting regular updates. [28]

Mental health and substance use disorder services are not included in Medicaid network adequacy standards because they are carved out of the MCO benefit package and managed by an administrative services organization. Medicaid does contract with any willing mental health and substance use disorder provider who meets licensure requirements and other conditions for participation as outlined in COMAR.[29]

On the federal level, CMS recently proposed new Medicaid regulations that may change how states assess network adequacy for managed care entities. The language in proposed 42 CFR §438.68 may require states to develop time and distance standards in the future for primary care for adult and pediatric services, specialty care for adult and pediatric services, hospitals, pharmacies, pediatric dental services, OB/GYN, and behavioral health, along with other services CMS may identify in the future.[30]

Medicare Requirements

CMS (2014) sets the following provider network adequacy requirements for Medicare Advantage plans (CMS, 2014):

- Minimum number of providers per specialty per county: This is based on 1) multiplying the 95th percentile of Medicare Advantage market penetration rates for each county by the number of Medicare beneficiaries in that county, and 2) a minimum provider ratio that is based on primary and secondary research on the utilization and health needs of Medicare beneficiaries. To calculate the minimum number of providers by specialty type for each county, the estimated number of beneficiaries is multiplied by the minimum provider ratio and rounded up to the nearest whole number.

[28] COMAR 10.09.66.02(C).

[29] Licensure requirements and other conditions for participation are outlined, generally, at COMAR 10.09.36.02-.03, and further, throughout COMAR 10.09 depending on the provider type.

[30] See Fed Reg 31271(proposed June 1, 2015)

- Maximum travel time and distance to providers: Plans must ensure that least 90 percent of beneficiaries in each county have access to at least one provider, for a given specialty, within CMS's published time and distance standards.

CMS will consider requests for exceptions to these standards under limited circumstances.

Continuity of Care Requirements

Related to network adequacy, Maryland also has continuity of care protections. The MHBE Act of 2012 required the MHBE to study and make recommendations on requirements for continuity of care in Maryland's health insurance markets. To address this mandate, the MHBE convened a continuity of care advisory committee and made recommendations to the Maryland General Assembly. As a result, the Maryland Health Progress Act of 2013 enacted the following continuity of care provisions for individuals transitioning between health plans:[31]

- A receiving carrier or MCO shall accept a preauthorization from a relinquishing carrier, MCO, or third-party administrator for covered services.
- A receiving carrier or MCO shall allow a new enrollee to continue to receive health care services rendered by a non-participating provider at the time of transition for acute conditions, serious chronic conditions, pregnancy, mental health conditions, substance use disorders, and any other condition on which the non-participating provider and the receiving carrier or MCO reach agreement.

Both provisions are time-limited and apply to the lesser of the course of treatment or 90 days, or the duration of a pregnancy and initial postpartum visit. These provisions apply to contracts issued or renewed on or after January 1, 2015.

Other Considerations

National Association of Insurance Commissioners

In 1996, the National Association of Insurance Commissioners (NAIC) adopted the Managed Care Network Adequacy Model Act #74, which required managed care plans to maintain networks that ensure access to services "without unreasonable delay." The ACA adopted a similar standard (Corlette, Volk et al., 2014). The model act applies to all managed care plans, defined as any benefit plan that uses incentives for a covered person to use in-network health care providers (NAIC, 1996). The model act was intended to establish standards for the creation and maintenance of health insurance carrier provider networks and to assure the adequacy of a managed care plan's health care services by establishing requirements for agreements between insurers and providers (NAIC, 1996).

[31] Insurance Article, §15-140, Annotated Code of Maryland.

Under the model act, an insurance carrier is required to maintain a network that is sufficient in numbers and types of providers to assure that all covered services will be accessible without undue delay (NAIC, 1996). If an enrollee cannot receive a covered benefit in-network, then the enrollee must be allowed to go out-of-network at no additional cost (NAIC, 1996). A carrier should monitor the ability, financial capability, and legal authority of its providers to deliver all contracted benefits to enrollees (NAIC, 1996). Carriers should also file an access plan with the state insurance commissioner that describes the carrier's network, standards, and procedures (NAIC, 1996). Selection criteria for providers should not allow carriers to avoid high-risk populations by excluding providers who are located in areas with a high-risk population or who treat high-risk populations (NAIC, 1996). The model act does not include specific quantitative standards, such as maximum wait times or travel distances. Instead, it uses more subjective standards. Seven states adopted the model act: Colorado, Mississippi, Missouri, Montana, Nebraska, New Jersey, and Tennessee (NAIC, 1996).

In June 2012, the NAIC released a white paper on network adequacy to provide a framework for states to consider when developing ACA-compliant network adequacy standards for QHPs and managed care plans outside of an exchange (NAIC, 2012). It also provided a detailed comparison of the model act and the ACA rules. The model act needs modification to include ECPs, mental health, and substance abuse providers in networks, as these providers are specifically required under the ACA (NAIC, 2012). The model act also needs to include the ACA requirement that insurers make their QHP provider directories available to the exchange for publication online and in hard copy upon request, specifying which providers are not accepting new patients (NAIC, 2012). The NAIC has therefore convened a workgroup—the Network Adequacy Model Review Subgroup—to review and consider revisions to the model act.

The NAIC released a draft Health Benefit Plan Network Access and Adequacy Model Act in November 2014, revised to reflect the new requirements under the ACA (NAIC, 2014). The draft model act includes a requirement that insurers make their QHP provider directories available online, updated monthly, and provides more detailed requirements for allowing an enrollee to go out of network if a covered benefit is not available in network (NAIC, 2014). The draft model act includes a definition of ECP to alert states of the requirement under the ACA to include ECPs in QHP networks, but it does not include any requirements or standards regarding ECP participation (NAIC, 2014). As of this report, the final version of the model act is still pending. The NAIC released a revised draft model act on September 1, after the Workgroup concluded its meetings.

Balancing Access and Costs

Before the ACA, health insurers had several methods available to control costs, such as benefit exclusions, annual or lifetime benefit limits, high deductibles, and the exclusion of pre-existing health conditions (Corlette, Volk, et al., 2014). These options are no longer available under the ACA (Corlette, Volk, et al., 2014). As a result, narrowing provider networks is one of the allowable methods insurers can use to control costs. However, if a network is too narrow, it

could prevent enrollees from accessing covered health services in a timely manner. This has led to debate among stakeholders over whether a health plan's efforts to lower costs through narrow networks jeopardizes the plan's ability to provide covered health services to enrollees without undue delay or burden.

A study commissioned by America's Health Insurance Plans (AHIP) argues that narrow networks can help reduce premiums while still delivering high quality health services (O'Connor & Spector, 2014). The strategy behind narrow networks is to optimize patient care while controlling costs by contracting with more efficient and lower cost providers (O'Connor & Spector, 2014). This study found that QHPs with narrow networks had 5 to 20 percent lower rates than plans with broad provider networks (O'Connor & Spector, 2014). The amount of premium reduction is dependent upon several characteristics of the provider network. These characteristics include plans choosing providers that have lower charges, providers agreeing to lower rates, utilization management, anticipated reductions in service utilization due to the characteristics of people attracted to narrow network plans, and anticipated increases in utilization of out-of-network providers (O'Connor & Spector, 2014). The study also found that health plans consider several criteria when selecting providers for their network. At the outset, health plans will ensure that their networks comply with applicable network adequacy standards under state and federal law. Plans will typically select providers based on quality measures and then consider fee levels when making a final decision (O'Connor & Spector, 2014). The selection of lower cost and more efficient providers allows health insurers to provide enrollees access to covered medical services while lowering premiums.

Consumer advocates and provider groups argue that narrow networks may limit access to health services. The American Medical Association (AMA) expressed concern that state and federal regulators may not be able to adequately assess and monitor network adequacy, which could put patients' access to care at risk (2014). The sickest patients may not have access to needed medical care if insurers select providers based on cost alone or use inaccurate data when making their selections (AMA, 2014). The AMA (2014) suggested that patients and providers are not being adequately notified when existing plans are narrowing their networks. Provider directories often contain inaccurate or outdated provider information, preventing patients from making informed decisions (AMA, 2014). Lastly, patients who chose plans based on lower premiums may be unaware that their new plan has a smaller provider network, and they may have to pay higher deductibles and other out-of-pocket costs to access necessary out-of-network care (AMA, 2014).

Consumers themselves may prefer plans with narrow networks because of the lower premiums. A survey by the Kaiser Family Foundation found that individuals likely to enroll in coverage through exchanges were more likely to prefer less costly plans with narrow networks than more expensive plans with broader networks (Hamel, Firth, & Brodi, 2014). The survey found that the general public prefers plans with broader networks, with 51 percent responding that they would rather have a more expensive plan with a broader network (Hamel et al., 2014). However, 54 percent of the people most likely to enroll in exchanges prefer a less costly narrow network plan,

and only 34 percent of this group prefers a broad network (Hamel et al., 2014). An important finding of this survey is that when presented with the possibility of not being able to use their current providers, the share of people who prefer narrow networks drops from 54 percent to 35 percent among the uninsured and those with individual coverage (Hamel et al., 2014). Inversely, when those who prefer a broad network plan are told that they could lower their premiums by 25 percent, the share who prefer the more expensive option drops from 35 percent to 22 percent among those who are uninsured and those with non-group coverage (Hamel et al., 2014).The results of this survey show that cost is a very important factor that consumers consider when choosing their plan, but that consumers are also reluctant to give up their current providers for a less expensive plan with a narrow network.

Analysis of National Exchange Networks

In June 2014, the McKinsey Center for U.S. Health Reform released a study of all insurers filing on the 2014 exchanges (Bauman, Coe, Ogden, & Parikh, 2014). This study examined hospital participation in QHP networks, and included all 2014 exchange plans and all acute care hospitals in the U.S. The McKinsey Center recently updated its network database to include all networks offered through the exchanges during 2015 (Bauman, Bello, Coe, & Lamb, 2015.) Over 1,000 new networks were introduced in 2015; the database now includes 2,930 exchange networks from 333 insurers, and 4,698 acute care hospitals (Bauman et al., 2015). Network classifications were based on the percentage of acute care hospitals participating in a plan's network; the study did not examine physician participation (Bauman et al., 2015). Broad networks were defined as networks with more than 70 percent of available hospitals; narrow networks included 31 to 70 percent of available hospitals; and ultra-narrow networks included 30 percent or less of available hospitals (Bauman et al., 2015). Similar to 2014, narrow networks made up 45 percent of all exchange networks across the country in 2015, and 62 percent of the networks in the largest city in each state (Bauman et al., 2015). Among all re-filed 2014 plans, narrow network plans had a median premium increase of 4 percent, and broad network plans had an 8 percent increase (Bauman et al., 2015). For 2015, the median premiums of broad-network plans are 15 to 23 percent higher than narrow network plans (Bauman et al., 2015).

The McKinsey study also included a consumer survey that assessed consumer's knowledge and experience with their networks (Bauman et al., 2015). Many consumers did not understand their plan choices: in fact, 44 percent of consumers who bought a QHP for the first time reported that they did not know their plan's network configuration, and 19 percent of consumers who purchased a QHP last year also reported that they were unaware of their plan's network configuration (Bauman et al., 2015). The survey found that 66 percent of consumers who enrolled in a 2014 narrow network plan felt that they had sufficient access to providers, while 90 percent of enrollees in broad network plans were satisfied with their provider access (Bauman et al., 2015). Despite the lower approval rate among enrollees in plans with narrow networks, only 17 percent of those with a narrow network plan in 2014 switched to a broad network plan during 2015 (Bauman et al., 2015).

In September 2014, the Robert Wood Johnson Foundation published a study assessing the provider network changes and efforts at regulatory oversight of network adequacy in six states: Colorado, Maryland, New York, Oregon, Rhode Island, and Virginia (Corlette, Lucia, & Ahn, 2014). The study found that in four of these states, insurers in the individual market modified their provider networks in preparation for 2014 (Corlette, Lucia et al., 2014). In Maryland and Rhode Island, insurers did not make significant changes to their networks for 2014, but some insurers narrowed their networks to offer lower premiums for their 2015 plans (Corlette, Lucia, et al., 2014). All insurers were focused on the pricing of their plans, with many indicating that they used narrower networks to lower premiums in the individual market and attract consumers (Corlette, Lucia, et al., 2014). Insurers generally did not report any efforts to design networks based on quality metrics but rather focused on pricing (Corlette, Lucia, et al., 2014). Insurers used a variety of approaches to network design, including eliminating out-of-network coverage, using tiered provider networks, or screening out the most expensive hospitals. Generally, insurers made fewer changes to plans in the small group market (Corlette, Lucia et al., 2014).

Officials in all six states expected insurers to narrow networks even further in 2015. The study found that while insurers in Maryland did not narrow their networks in 2014, at least one insurer planned to offer a narrower network in 2015. Maryland's largest insurer did not expect to modify its network for 2015 (Corlette, Lucia, et al., 2014). Overall, insurers and regulators reported receiving few complaints about plans' provider networks (Corlette, Lucia, et al., 2014). However, there was confusion among both consumers and providers about which providers were participating in a plan's network, and there were requests for more accurate and up-to-date provider directories (Corlette, Lucia, et al., 2014). Only New York and Rhode Island modified their network adequacy standards for 2015; the other states generally felt it was too early to develop standards and are still collecting information (Corlette, Lucia, et al., 2014). Three states were adopting new rules to require insurers to improve the accuracy of their provider directories (Corlette, Lucia, et al., 2014). The study found that there was a clear trend that insurers were offering narrower networks to lower premiums in the individual market (Corlette, Lucia, et al., 2014). Despite concerns from some regulators, consumer advocates, and providers that narrow networks could negatively impact consumers' access to quality care, most of the studied states were not planning to significantly change their network adequacy standards (Corlette, Lucia, et al., 2014).

Network Adequacy Data Sources in Maryland

The following section of this report provides a brief overview of the more prominent Maryland data sources on network adequacy that are currently available.

MHBE Data

Carrier Access Plans

As part of its QHP certification process, the MHBE requires carriers to submit an access plan with information on network adequacy and the inclusion of ECPs. The MHBE provides carriers with an access plan template to complete.

Provider Directory

The MHBE contracts with the Chesapeake Regional Information System for Our Patients (CRISP) to maintain a provider directory for all of the QHPs participating in the MHBE. The directory contains information such as provider names, provider addresses and demographic information, the carriers with which the provider is participating, indicators of whether the provider is a PCP, provider specialties, and indicators of whether or not the provider is an ECP. A complete and accurate provider directory has the potential to provide the MHBE with information about the number and types of providers available in the QHP networks. Each carrier is also required to maintain its own provider directory, separate from the directory housed by CRISP.

Enrollment

The MHBE collects eligibility and enrollment information submitted by individuals in their applications for QHP coverage. Combining QHP enrollment information with provider directory information can allow the MHBE to compare the size of the enrolled QHP population with the size of the provider network (overall and within certain jurisdictions).

Maryland Health Care Commission (MHCC) Data

Medical Care Database (MCDB)

MHCC develops and maintains the state's MCDB, an all-payer claims database. The MCDB includes health care practitioner, prescription drug, institutional service, eligibility, and provider data from carriers doing business in Maryland whose total covered lives exceed 1,000, including qualified health, dental, and vision plans certified by the MHBE. QHP claims in the MCDB could potentially be used to perform various access and utilization measures, which may provide insight into network adequacy.

Health Benefit Plan Quality Reports[32]

MHCC releases an annual comprehensive quality report that compares the performance of Maryland's commercial health insurance plans. The report includes detailed information on plan performance from an extensive list of measures and indicators related to clinical performance and member satisfaction with the quality of health care service delivery measures and many other topics. The report includes the total number of providers for each carrier broken down by specialty and county.

MIA Data

Availability Plans

MIA regulations require carriers to implement an availability plan, laying out the "quantifiable and measurable standards for the number and geographic distribution of" several types of providers, ranging from internal medicine providers to high-volume specialty mental health and substance use disorder providers.[33] In addition to these standards, the availability plan must include the methods used to 1) assess compliance with the standards set in the plan, 2) ensure timely access to health care services, and 3) monitor and ensure the sufficiency of the provider panel.[34] Prominent carriers—those reporting at least $90,000,000 in written premium—are required to file their plans with the MIA.[35]

Maryland Medicaid Data

The Medicaid Management Information System (MMIS2) contains eligibility information, claims/encounters, and provider information for the entire Maryland Medicaid program. The MMIS2 contains both MCO encounters and FFS claims, including carved-out mental health and substance abuse services that are managed by ValueOptions, an administrative services organization. The MMIS2 provider directory contains information about participating providers, including mental health and substance abuse providers and programs. While not specific to QHP network adequacy, these data are used for monitoring network adequacy and access to care in Medicaid and may be useful for evaluating continuity of care between Medicaid and QHPs and related issues.

---

[32]Available at http://mhcc.maryland.gov/mhcc/pages/apcd/apcd_quality/apcd_quality_hbp.aspx
[33] COMAR 31.10.34.05(A)(1).
[34] COMAR 31.10.34.05(B).
[35] COMAR 31.10.34.05(C)(2).

Policy Options

At the outset of the meeting process, the Workgroup reviewed federal and state law related to network adequacy and ECPs. The Workgroup also reviewed federal and state-level network adequacy data sources and became familiar with the network adequacy and ECP standards being developed in other states. Reflecting on the discussions at these meetings, the Workgroup then developed policy options for the MHBE's consideration, providing advantages, disadvantages, and other considerations for each. The options are intended to provide a range for consideration and could be implemented in isolation or in combination with other options. Workgroup members and the public were given the opportunity to comment on these options. Public comments are included in Appendix B and Attachment 1.

In analyzing these policy options, the Workgroup was cognizant of several considerations. The Workgroup considered the impact of any decisions on the overall commercial health insurance market in the context of the purview of the MHBE's statutory authority; the timing of this report with the revised NAIC Model Act; and whether the options discussed would be feasible to put into operation by the MHBE in light of its budget and staff capacity. The following policy options were discussed by the Workgroup.

1. Data Collection and Reporting Policy Options:

A. The MHBE should work with MHCC to analyze network adequacy using claims and encounter data.
B. The MHBE should work with the licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers in the state and other data, such as provider specialty.
C. The MHBE should work with Medicaid and other divisions of DHMH to assess the number, capacity, and types of providers in the state, especially mental health and substance use disorder providers, provider organizations, and programs, in order to identify willing providers.
D. The MHBE should work with the MHCC, providers, payers, carriers, and consumer groups to expand the consumer satisfaction data collected and made accessible, and determine specific ways to make the data more transparent to the public (e.g., consumer report cards).

2. Provider Directory Policy Options

A. The MHBE should work with the MIA, carriers, providers, and consumer groups to improve the accuracy of provider directories.

B. The MHBE should expand on the types of providers that are included in provider directories, such as including mental health and substance use disorder programs, in addition to individual practitioners.

C. The MHBE should consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories.

D. The MHBE should assess the feasibility of developing a standard taxonomy for provider types.

3. ECPs

A. The MHBE should expand the definition of ECPs beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers.

B. The MHBE should work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate and complete.

C. The MHBE should use the FFM threshold for ECP participation and the FFM alternate standard for qualifying carriers.

4. Quantitative Standards

A. The MHBE should collect data regarding network adequacy and consider developing quantitative standards in the future.

B. The MHBE should work with the MIA, consumer groups, and carriers to define the current unreasonable delay standard so that consumers will better understand when they can see an out-of-network provider with in-network cost-sharing.

C. The MHBE should work with the MIA to make the quantitative standards used and reported by carriers in their availability plans submitted to the MIA and access plans submitted to the MHBE publicly accessible.

D. The MHBE should work with the MIA to standardize the format for reporting quantitative standards in availability plans the MIA requires, and with DHMH to standardize the format for reporting quantitative standards in availability plans DHMH requires.

5. Informing Consumers

A. The MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the Office of the Attorney General's Health Education and Advocacy Unit (HEAU) to develop messaging and a reasonable process to inform consumers on how to find a

provider and how to obtain relief when they cannot find a provider, pursuant to Ins. Art. §15-830(d).

Areas of Consensus

The Workgroup reached consensus on seven policy options. There was general consensus in support of the MHBE working with MHCC to analyze network adequacy through claims and encounter data to identify patterns and systematic problems. The Workgroup also agreed that the MHBE should work with Medicaid and other divisions of DHMH to assess the number, capacity and types of providers in the state in order to identify willing providers. There was also general consensus that the MHBE should work with the licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers in the state and other data, such as provider specialty.

Regarding provider directories, there was consensus that the MHBE should work with the MIA, carriers, providers, and consumer groups to improve the accuracy of the provider directory and make it more useful for consumers. The Workgroup also agreed that the MHBE should consider whether there should be portals through which providers and consumers can communicate information about the accuracy of the provider directory.

There was general consensus supporting an ECP policy option that the MHBE should also work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate and complete.

Lastly, the Workgroup agreed that the MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the HEAU to develop messaging and a reasonable process to inform consumers on how to find a provider and how to obtain relief when they cannot find a provider.

The next section of this report summarizes the potential advantages, disadvantages, and other considerations for each policy option discussed by the Workgroup.

1. Data Collection and Reporting Policy Options

Option 1A. The MHBE should work with MHCC to analyze network adequacy through claims and encounter data.

There was general consensus in support of this policy option by the Workgroup members.

1A. Potential Advantages

Many members commented that the information gleaned from the claims data can assist in determining patterns and systemic problems, such as a significant number of out-of-network claims for a certain specialty. Reasons offered for this advantage were:

- The database indicates whether a type of service is provided in network or out of network.
- Claims data depict the activity level of a provider (i.e., whether the provider is actively seeing patients).
- The data can show whether a provider is accepting new patients through procedure coding on the claim.
- Claims can be separated into inpatient and outpatient categories to determine access problems by facility type.

1A. Potential Disadvantages

Several members commented that the database's limitations would have to be accounted for if the data are to be helpful. Limitations mentioned included:

- Out-of-network information is only available for preferred provider organizations (PPOs).
- The data do not indicate why a consumer received a service out of network.
- Data will have to be verified by other sources.
- The data are not able to show "no access," so there will be no claims where there is difficulty accessing a specific type of provider.
- There is a lag time in claims submission.
- Claims data may be submitted from a billing office, rather than a provider's office, which may be problematic for analyses using address information linked to claims.

1A. Other Considerations

- The variables selected for analysis and the analytic approach will require careful consideration.
- This option would require significant interagency collaboration, and any additional work required to facilitate analysis of the claims data would have corresponding budgetary considerations for both the MHCC and the MHBE.
- The data may not help identify specific network adequacy issues.

- Analysis of claims and encounters data for purposes of evaluating network adequacy must take into account any differences in the elements or formatting of data submitted by integrated delivery systems.

Option 1B. The MHBE should work with the licensure boards, providers, carriers, MHCC, and consumer groups to expand licensure data collection in order to better assess the number of active providers in the state and other data, such as provider specialty.

There was general consensus in support of this policy option by the Workgroup members.

1B. Potential Advantages

Members commented that licensure boards have the most complete list of providers practicing in the state. A few of these boards have expanded data collection capabilities, which can also help the state address additional workforce questions.

1B. Potential Disadvantages

There was consensus among the Workgroup that the licensure boards have a broad range of data collection capabilities, which would be a considerable obstacle in performing any substantial analysis of the data.

1B. Other Considerations

Members discussed that, given the broad range of data capabilities across the licensure boards and the information that can therefore be obtained from an analysis of these data, availing this option may be less of a priority in the context of the other policy options. On the other hand, working with the licensure boards provides an opportunity to partner with other state agencies.

Option 1C. The MHBE should work with Medicaid and other divisions of DHMH to assess the number, capacity, and types of providers in the state, especially mental health and substance use disorder providers, provider organizations, and programs, in order to identify potential provider shortages and identify willing providers.

There was general consensus in support of this policy option by the Workgroup members.

1C. Potential Advantages

- Medicaid mental health and substance use disorder provider data are more comprehensive, capturing most licensed mental health and substance use disorder programs in the state.

- Comparing networks between Medicaid and QHPs could be advantageous for assessing network adequacy in the context of continuity of care for individuals who transition in eligibility between Medicaid and QHPs (the "churn" population).
- Medicaid may be the source of the most robust information, as it has information on the program level (e.g. a community-based methadone treatment program), as well as the provider or clinician level.

1C. Potential Disadvantages

- Substance use treatment programs that participate in QHP networks may not align with those participating in Medicaid's network. Any analysis of Medicaid and QHP networks will therefore have to account for the fact that neither the networks, nor the network adequacy requirements, are comparable.
- Along the same lines, the utility of the comparison will vary, as Medicaid has an "any willing provider" standard for providers specializing in mental health and substance use disorder, but not for other specialties.
- Data collection may be difficult and the limitations of the data will need to be accounted for in any analysis.

1C. Other Considerations

- The size of the enrollee population has an impact on network design. For example, the size of the Medicaid population is significantly larger than the size of the enrollee population for a new QHP carrier.

Option 1D. The MHBE should work with, MHCC, providers, payers, carriers, and consumers groups to expand the consumer satisfaction data collected and made accessible, and determine specific ways to make the data more transparent to the public (*e.g.*, consumer report cards).

There was no consensus among the Workgroup on this policy option.

1D. Potential Advantages

Providing additional consumer satisfaction data to consumers, in specific manners that allow them to easily access and understand the data, will allow them to make more informed QHP selections.

1D. Potential Disadvantages

Consumer satisfaction data may not fully capture network adequacy issues and should therefore be used in conjunction with access and quality metrics.

1D. Other Considerations

The MHBE should work with the above-mentioned agencies to include these data. Further, any QHP-specific quality data provided to the public will need to address issues with the first open enrollment. The MHBE may also have budgetary concerns related to making QHP-specific quality data available, as it may be very costly to isolate this data from MHCC's commercial market quality reports.

2. *Provider Directory Policy Options*

Option 2A. The MHBE should work with the MIA, carriers, providers, and consumer groups to improve the accuracy of provider directories.

There was a general consensus and support for this policy option by the Workgroup members.

2A. Potential Advantages

- More accurate and transparent information regarding providers that are participating in a network and accepting new patients would make the directories more useful for consumers.

2A. Potential Disadvantages

- No potential disadvantages were offered.

2A. Other Considerations

- Some members commented that in large medical practices, individual providers may not know which plans they accept, which could prevent them from properly updating provider directories. Members also discussed whether the MHBE should enact standards to improve the transparency of providers' availability in directories.
- Members discussed using claims data to identify active providers in a network to improve the accuracy of the provider directory information.
- Some members expressed concern that there is limited enforcement to ensure that providers promptly update provider directories, which is necessary for the information to be accurate.

Option 2B. The MHBE should expand on the types of providers that are included in provider directories, including mental health and substance use disorder programs, in addition to individual practitioners.

2B. Potential Advantages

Workgroup members commented that provider directories should allow program names to be listed rather than the individual providers because, in many cases, substance use disorder treatment is delivered through programs—as opposed to individual practitioners. This approach could be applied to other community-based organizations that deliver health care services.

2B. Potential Disadvantages

Some workgroup members expressed concern that this approach would require carriers and CRISP to change their systems.

Option 2C. The MHBE should consider whether there should be portals through which providers and consumers can communicate information about the accuracy of provider directories.

There was consensus in support for this policy option by the Workgroup members.

2C. Potential Advantages

- Some workgroup members commented that consumers may have the most up-to-date information based on their experience trying to contact a provider.
- Workgroup members commented that allowing consumers to indicate if a provider's directory information is incorrect could reduce the burden on carriers to identify inaccurate information.
- DC Health Link (Washington DC's Health Benefit Exchange) already has a system in place that the MHBE can learn from.
- A single portal system has advantages for providers, as they do not need to update their information in multiple places (e.g., CRISP and the carrier provider directory).

2C. Potential Disadvantages

Some members expressed concern that this approach could cause inconsistencies between the portal and the provider directories displayed on the carriers' websites. Similarly, members commented that if providers can directly relay information to a portal such as CRISP, then it could result in inaccuracies because it is possible that not all of the provider's locations are included within a carrier's network.

2C. Other Considerations

Workgroup members discussed using the Council for Affordable Health Care (CAQH) database to link all of the carriers so that provider directories in the portal can be updated more easily.

Option 2D. The MHBE should assess the feasibility of developing a standard taxonomy for provider types.

2D. Potential Advantages

- A standardized taxonomy would improve consistency across all provider directories and more accurately capture all available specialties.

2D. Potential Disadvantages

- Creating a standardized taxonomy would be resource intensive for the MHBE.

2D. Other Considerations

- Carriers have previously discussed the display of provider directory information during the Exchange Implementation Advisory Committee (EIAC) meetings. These discussions can help inform any development of a standard taxonomy.

3. ECP Policy Options

Option 3A. The MHBE should expand the definition of ECPs beyond the federal definition to include local health departments, mental health and substance use disorder providers licensed by DHMH as programs or facilities, and school-based health centers.

3A. Potential Advantages

- Broadening the definition would help support network adequacy for people that are underserved.
- Some workgroup members commented that expanding the definition of ECPs would allow providers already seeing the low-income, medically needy population to bill carriers.
    - Because these are historical providers for the low-income, medically needy populations, individuals in these populations would be able to continue seeing them after enrolling in a QHP, which would provide continuity of care.

- If designated as ECPs, they would be able to reimbursed, which would strengthen the care and services provided by creating the ability to expand capacity and operations

3A. Potential Disadvantages

In expanding the definition of ECPs, members expressed concern that some potential ECP providers may not have experience working with carriers. Some carriers commented that increasing the number of ECPs without clear adjustments and allowances for providers who cannot contract with carriers is problematic.

3A. Other Considerations

- Members discussed that, for certain mental health and substance use disorder providers, such as outpatient mental health clinics and substance use treatment programs, the clinic or program should be considered an ECP rather than the individual providers because the program is identified in the community as providing the service and meets the ECP definition. Members mentioned that Maryland regulations likely include a list of the types of mental health and substance use disorder programs that can be referenced when expanding the definition of ECPs. Some members suggested that it may be difficult to define ECPs in manner that is specific enough to clearly identify which providers are ECPs and which are not.
- Providers must be able to meet carrier's requirements related to licensure and credentialing.
- The credentialing process is difficult and is a barrier for providers wanting to participate in networks.
- Members commented that the federal definition of ECPs may be changing soon, so the MHBE may want to consider waiting to make a decision until the federal definition is finalized. Other members commented that other states have nevertheless expanded the definition of ECP, which can provide Maryland guidance in defining ECPs.

Option 3B. The MHBE should work with state partners to create an ongoing process, using Maryland data sources, to ensure that the CMS list of Maryland ECPs is accurate and complete.

There was general consensus among Workgroup members supporting the improvement of the list of ECPs.

3B. Potential Advantages

- CMS's non-exhaustive list of ECPs is not accurate and needs improvement.

- An accurate ECP list will improve transparency regarding which providers are serving the low-income, medically needy population.
- An accurate list of ECPs will be needed before any standards regarding ECP participation are adopted.

3B Potential Disadvantages

- No potential disadvantages were offered.

3B. Other Considerations

- Members commented that the list would have to be specific and updated regularly by a designated agency or organization to maintain accuracy. Members discussed that Maryland could develop a process to capture all the ECPs in Maryland and provide that information to CMS to include in its list.
- Members expressed concern that updating the list would require state resources and coordination between the MHBE and DHMH.

Option 3C. The MHBE should use the FFM threshold for ECP participation and the FFM alternate standard for qualifying carriers.

3C. Potential Advantages

- Members commented that using the FFM threshold would improve transparency and provide a measureable standard for ECP participation in Maryland.

3C. Potential Disadvantages

- Some carriers expressed concern that adopting the federal threshold in combination with expanding the definition of ECPs could increase contracting pressure on carriers.

3C. Other Considerations

- Members commented that before the FFM threshold can be adopted, the MHBE would have to determine whether to use the CMS list of ECPs, which HHS currently uses to determine compliance with the FFM threshold, or another list to assess the threshold.

4. *Quantitative Standards Policy Options*

The conversation around the first two quantitative standards policy options did not follow the normal format in that members did not lay out explicit advantages and disadvantages for most of

the options. Rather, they developed and weighed some new alternatives, discussing considerations for each alternative that are reflected here.

Option 4A. The MHBE should collect data regarding network adequacy and consider developing quantitative standards in the future.

In the discussion of this policy option, two possibilities emerged:

- Wait for the NAIC Model Network Adequacy Act and then determine what kind of quantitative standards, if any, should be implemented.
- Set a specific deadline for the development of quantitative standards, such as no later than the 2018 plan year.

4A. Considerations related to waiting for the NAIC Model Network Adequacy Act before further pursuing this option

- Some members discussed that this option allows for a more informed decision on the types of quantitative standards the state should consider; it is premature for the state to develop its own quantitative standards with the Model Act still pending.
- Other members commented that the Model Act will recommend the use of quantitative standards, but the NAIC will still leave implementation of specific standards to the states.

4A. Considerations related to setting a specific deadline for quantitative standards

- A few members urged that it would benefit the state to have an actual date to work toward.
- Setting a date in the near future would require convening a workgroup and developing a timeline for the creation of standards very soon.

4A. Other Considerations

- Any standards developed would have to take into account the demographic, geographic, and other related factors for the various regions in the state. There cannot be a single, uniform standard for the entire state.
- It is important to think about how the state will measure certain quantitative standards and the implications of the method of measurement for each. For example, if a maximum wait time standard is measured only by complaints, the standard has little meaning unless and until an enrollee is aware of the standard and voices a complaint regarding noncompliance with the standard.
- There are cases where consumers choose providers beyond the prescribed maximum travel time or with a wait longer than a maximum wait time based on the provider's

expertise and reputation. This does not mean that carriers do not have providers within the network that can meet the quantitative standards, but an enrollee may not want to visit those providers. Any quantitative standards developed should account for such situations.

- Any standards set should account for emergent and non-emergent care.
- The MHBE should consider performing a cost-benefit analysis for developing standards, as it is a complex issue with implications for all stakeholders (i.e., providers, carriers, and consumers).
- The impact of setting standards, whether just for QHPs or market-wide, on the overall commercial insurance market should be considered.
- Any standards developed should include a safe harbor or ability to provide a justification for not meeting a quantitative standard.
- Any standards developed should account for integrated delivery systems.

Option 4B. The MHBE should work with the MIA, consumer groups, and carriers to define the current unreasonable delay standard so that consumers will better understand when they can see an out-of-network provider with in-network cost-sharing.

There was no Workgroup consensus in support of this policy option.

4B. Potential Advantages

- Providing guidance for this standard to consumers will help them know when to take action, such as reaching out to the MIA.

4B. Potential Disadvantages

- Determining compliance with this standard is dealt with on a case-by-case basis, so creating a standard requirement for the definition could be problematic.

4B. Other Considerations

- Defining this standard will help get to a wait time and/or travel time quantitative standard. Such standards are more beneficial than a provider-to-enrollee ratio standard.
- The unreasonable delay standard applies to the entire commercial market, but the MHBE Board can implement standards only for QHPs. Therefore, any change regarding this standard would require a statutory change.
- Members suggested that the MIA can inform the public of the current standard, without further defining it through legislation.

- There was consensus among the group on placing information about this standard in the provider directory, including a contact number for enrollees when they believe a carrier is not complying with the standard.
- The MHBE and MIA should consider defining the standard for urgent situations.

Option 4C. The MHBE should work with the MIA to make the quantitative standards used and reported by carriers in their availability plans submitted to MIA and access plans submitted to the MHBE publicly accessible.

There was no workgroup consensus in support of this policy option.

4C. Potential Advantages

- This option improves transparency, which may eliminate the need to set uniform quantitative standards.

4C. Potential Disadvantages

- Carrier availability plans and access plans may contain proprietary information.
- Making this information public does not directly improve network adequacy.
- Providing this information to consumers may be overwhelming; the information provided to consumer should be useful.

4C. Other Considerations

- Members suggested that the state develop a compromise by which only some, non-proprietary information is made accessible.
- Members suggested balancing the release of this information and equipping regulators with the ability to enforce standards.

Option 4D. The MHBE should work with the MIA to standardize the format for reporting quantitative standards in availability plans the MIA requires, and with DHMH to standardize the format for reporting quantitative standards in availability plans DHMH requires.

There was no consensus among the Workgroup in support of this policy option as it is currently stated. Members indicated that their support would depend on the format developed (e.g., if it would require new data collection or reporting).

4D. Potential Advantages

- A uniform format will help carriers understand exactly what they need to submit to state agencies.
- A uniform format may in fact require less information than some carriers already provide, making submissions less resource-intensive.
- This option could help better provide categories of standards carriers use, which can be used for future analysis.

4D. Potential Disadvantages

- This may be more of an administrative burden for some carriers.

4D. Other Considerations

- This option would require a rule-making and public input process.

5. *Informing Consumers Policy Options*

Option 5A. The MHBE should work with the MIA, carriers, consumer stakeholders, providers, and the HEAU to develop messaging and a reasonable process to inform consumers on how to find a provider and obtain relief when they cannot find a provider, pursuant to Ins. Art. §15-830(d).

There was Workgroup consensus in support of this policy option.

5A. Potential Advantages

There was general consensus and support for this policy option among the Workgroup members. No distinct advantages were offered.

5A. Potential Disadvantages

No distinct disadvantages were offered for this policy option.

5A. Other Considerations

- Workgroup members suggested that the MHBE work with the MIA's consumer education and advocacy unit and suggested that additional advertising is needed to make this unit better known to consumers.

- MIA collects complaint codes for network adequacy using standard codes from the NAIC. Some Workgroup members suggested that the MIA update their consumer complaint form to allow consumers to indicate difficulty with finding a provider.
- Some Workgroup members suggested that, if implemented, there should be data collection and a separate evaluation of this policy option.
- All materials developed from this policy option should be in consumer-friendly language.
- The MHBE should consider including information on telemedicine and out-of-state providers.

Next Steps

The Workgroup presented this report to the SAC on September 10, 2015, and MHBE staff provided the SAC and the public with the opportunity to submit written comments on the report. The SAC discussed the report and policy options during the September 10, 2015 public meeting. The MHBE staff will present this report to the MHBE Board on September 15, 2015. In October, the Board will begin discussing policy recommendations for the 2017 plan year, as it starts to set the QHP certification standards. The MHBE may convene the Workgroup again in the future to continually monitor these issues.

References

American Medical Association. (2014). *Issue brief: Network adequacy*. Retrieved from http://radiationtherapyalliance.com/newsletter/files/2014-07-ama-principles.pdf

Appleby, J. (2014, September). *Consumer group sues 2 more California plans over narrow networks*. Retrieved from http://kaiserhealthnews.org/news/consumer-group-sues-2-more-calif-plans-over-narrow-networks/

Bauman, N., Coe, E., Ogden, J., & Parikh, A. (2014, June). *Hospital networks: Updated national view of configurations on the Exchanges*. Retrieved from http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges

Bauman, N., Bello, J., Coe, E., & Lamb, J. (2015, April). *Hospital networks: Evolution of the configurations on the 2015 exchanges*. Retrieved from http://healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf

Carlson, J. (2013, October). *Exchange exclusion suit: Higher-cost hospitals may be affected*. Retrieved from http://www.modernhealthcare.com/article/20131012/MAGAZINE/310129971

California Department of Insurance (2015, January). *Notice of approval of emergency regulatory action: provider network adequacy emergency regulation*. Retrieved from http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/upload/nr012-NetworkAdequacyApproval.pdf

Centers for Medicare & Medicaid Services. (2014). *CY2015 MA HSD provider and facility specialties and network adequacy criteria guidance*. Retrieved from http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf

Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight. (2015). *Non-exhaustive list of HHS essential community providers* .Retrieved from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html

Corlette, S., Volk, J., Berenson, R., & Feder, J. (2014, May). *Narrow provider networks in new health plans: Balancing affordability with access to quality care*. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643

Corlette, S., Lucia, K., & Ahn, S. (2014, September). *Implementation of the Affordable Care Act: Cross-cutting issues six-state case study on network adequacy.* Retrieved from http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649

Giovannelli, J, Lucia, K, & Corlette, S. (2015, May). *Implementing the Affordable Care Act state regulation of marketplace plan provider networks*. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf

Hamel, L., Firth, J., & Brodi, M. (2014, February 26). *Kaiser health tracking poll: February 2014*. Retrieved from http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/

Health Resources and Services Administration. (2014). *State profile - Maryland*. Retrieved from http://datawarehouse.hrsa.gov/topics/HrsaInYour/HrsaInYourState.aspx?geocd=24

Kaiser Family Foundation. (2015). *Definition of essential community providers (ECPs) in marketplaces*. Retrieved from http://kff.org/other/state-indicator/definition-of-essential-community-providers-ecps-in-marketplaces/

McCarty, S. & Farris, M. (2013, August). *ACA implications for state network adequacy standards*. Retrieved from http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/08/aca-implications-for-state-network-adequacy-standards.html

National Association of Insurance Commissioners (1996). *Managed care plan network adequacy model act*. Retrieved from http://www.naic.org/store/free/MDL-74.pdf

National Association of Insurance Commissioners (2012). *Plan management function: Network adequacy white paper*. Retrieved from http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf

National Association of Insurance Commissioners (2014). *Health benefit plan network access and adequacy model act*. Retrieved from http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_draft_proposed_revisions_mcpna_model_act.pdf

NCQA. (n.d.a.). *Network adequacy and exchanges*. Retrieved from https://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf

NCQA (n.d.b.). *2014 NCQA health plan accreditation requirements*. Retrieved from http://www.ncqa.org/Portals/0/Programs/Accreditation/2014%20NCQA%20HP%20requirements%20and%20HEDIS%20Measures-2.pdf

NCQA. (2014, July 28). *NCQA updates health plan accreditation to address narrow networks*. Retrieved from http://www.ncqa.org/Newsroom/NewsArchive/2014NewsArchive/NewsReleaseJuly282014.aspx

NCQA. (2015, July 28). *NCQA releases new standards for health plans*. Retrieved from http://www.ncqa.org/Newsroom/NewsArchive/2015NewsArchive/NewReleaseJuly282015.aspx

O'Connor, J., & Spector, J. (2014, July). *High-value healthcare provider networks*. Retrieved from http://www.ahip.org/MillimanReportHPN2014/

Rosenbaum, S., Lopez, N., Mehta, D., Dorley, M., Burke, T., & Widge, A. (2013, December). *How are state insurance marketplaces shaping health plan design?* Retrieved from http://www.healthreformgps.org/wp-content/uploads/cmwf-1-gwu-12-30.pdf

Appendix A. Network Adequacy and ECP Workgroup Membership

Name	Affiliation
Robyn Elliott, Co-Chair	Public Policy Partners
Mark Haraway, Co-Chair	DentaQuest of Maryland and DentaQuest Mid-Atlantic
Salliann Alborn	Community Health Integrated Partnership
Donna Behrens	Maryland Assembly on School-based Health Care
Steve Davis	Fuse Health Strategies LLC
Lori Doyle	Community Behavioral Health Association of Maryland
Adrienne Ellis	The Mental Health Association of Maryland
Renee Ellen Fox	Institute for Healthiest Maryland
Michelle Green Clark	Maryland Rural Health Association
Lena Hershkovitz	HealthCare Access Maryland
Megan Mason	Maryland Insurance Administration
Matthew McClain	Public Health Policy & Planning, McClain and Associates, Inc.
Deborah Rivkin	CareFirst BlueCross BlueShield
Kimberly Robinson	League of Life and Health Insurers of Maryland, Inc.
Tanya Robinson	Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.
Ellen Weber	Drug Policy Clinic at the University of Maryland Carey School of Law

Appendix B. Written Public Comments and Additional Workgroup Member Comments

This report was posted for public comment on August 27, 2015, and members of the public were given the opportunity to submit written comments by September 4, 2015. The MHBE received comments from the following individuals and organizations.

1. Nancy Harrington, Greater Washington Society for Clinical Social Work
2. Barbara Cowan, Licensed Social Worker
3. Ruth Maiorana, Maryland Association of County Health Officers
4. Gene Ransom, MedChi
5. Michael Such, DaVita
6. Duane Taylor, The MidAtlantic Association of Community Health Centers
7. Ellen Weber, The Drug Policy Clinic of the University of Maryland Carey School of Law
8. Geralyn Trujillo, America's Health Insurance Plans
9. Stephanie Berry, Delta Dental of Pennsylvania
10. Natasha Mehu, Maryland Association of Counties
11. Leni Preston, Maryland Women's Coalition for Health Care Reform
12. Michelle Green Clark, Maryland Rural Health Association
13. Nancy Rosen-Cohen, National Council on Alcoholism and Drug Dependence – Maryland Chapter
14. Judith Gallant, Maryland Clinical Social Work Coalition
15. Tanya Robinson, Kaiser Permanente
16. Kery Hummel, Maryland Psychiatric Society
17. Colette McKie, Maryland Acupuncture Society

A summary chart, indicating only whether individuals stated support or concern about a specific option, is below. The comments are included in Attachment 1.

Summary Chart of Public Comments*

Name	Organization	Options					Other
		Data Collection	Provider Directories	ECPs	Quantitative Standards	Informing Consumers	
Nancy Harrington	Greater Washington Society for Clinical Social Work						Requests forum to discuss concerns
Barbara Cowan	Licensed Social Worker						Suggests policy to help provide in-network cost sharing for out-of-network providers while an individual looks for an in-network provider
Ruth Maiorana	MD Association of County Health Officers			Supports 3A; Raises concerns about 3C			
Gene Ransom	MedChi	Supports; Raises additional considerations	Supports	Supports	Supports; Raises additional considerations	Supports	
Michael Such	DaVita			Supports; Raises additional considerations	Supports; Raises additional considerations		
Duane Taylor	Mid-Atlantic Association of	Supports	Supports	Supports; Specifies	Supports	Supports	

* In analyzing this chart, it is important to note that generally, stakeholders are more likely to provide comments where they do not believe their issues or concerns were properly captured in the report.

The Hilltop Institute

Name	Organization	Options					Other
		Data Collection	Provider Directories	ECPs	Quantitative Standards	Informing Consumers	
	Community Health Centers			support of 3A.			
Ellen Weber	Drug Policy Clinic, University of MD Carey School of Law	Supports; Raises additional considerations	Supports; Raises additional considerations	Supports; Raises additional considerations	Raise concerns about 4A		
Geralyn Trujillo	America's Health Insurance Plans		Supports; Raises other considerations	Raises concerns about 3A	Supports "other considerations" for these options		
Stephanie Berry	Delta Dental of PA			Raises concerns about 3A; Supports 3B; Raises concerns about 3C			
Natasha Mehu	MD Association of Counties			Supports 3A			
Leni Preston	MD Women's Coalition for Health Care Reform		Raises additional considerations		Supports 4B and 4C; Raises additional considerations	Raises additional consideratio ns	Raises concern that report and policy options are not strong enough; Raises concern about background section of report
Michelle Green Clark	MD Rural Health Association	Supports 1A, 1B, 1C	Supports 2A and 2C	Supports 3A, 3B, 3C	Supports; Raises additional considerations	Supports	

The Hilltop Institute

Name	Organization	Options					Other
		Data Collection	Provider Directories	ECPs	Quantitative Standards	Informing Consumers	
Nancy Rosen-Cohen	National Council on Alcoholism and Drug Dependence-MD Chapter	Supports; Raises additional considerations	Supports 2B	Supports 3A	Supports; Raises additional considerations	Supports	
Judith Gallant	MD Clinical Social Worker Coalition		Supports 2A; Raises additional considerations				Concern about payment discrimination for licensed certified social workers-clinical
Tanya Robinson	Kaiser Permanente		Supports 2C; Raises additional concerns	Raises concerns about 3A and 3C	Raises concerns		
Kerry Hummel	MD Psychiatric Society	Raises additional considerations	Raises additional considerations	Supports 3A	Raises additional considerations		Raises concern about background section of report
Colette McKie	MD Acupuncture Society	Supports 1C	Supports 2B				Raises concern that acupuncture is not routinely included in networks

The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org